

Lenape Valley Foundation
Assertive Community Treatment (ACT) Referral Form

500 N. West Street, Doylestown, PA 18901
(P) 215-343-7696 (F) 215-343-3819

Client: Name: _____

ACT Eligibility Criteria

Funding: Consumer has Medical Assistance or is Dual Eligible (Medicare/Medicaid or MAWD): Yes/No

The Consumer must be at least 18 years of age, a resident of Central or Upper Bucks County, with a severe and persistent mental illness. The individual must meet **ALL** of the following criteria for diagnosis, treatment history, and functioning level:

1. Diagnosis: Primary diagnosis of schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R or any subsequent revisions thereafter). **Individuals with a primary diagnosis of a substance use disorder, mental retardation, or brain injury are not the intended consumer group.**

List Diagnosis: _____

AND

2. **Functioning Level: Global Assessment of Functioning Scale (As specified in DSM-IV R or revisions thereafter) ratings of 40 or below.**

Current GAF _____ Lowest in Last 6 Months _____

AND

3. Consumers who meet at least **two** of the following criteria:

- ___ At least two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months that can include admissions to the psychiatric emergency services;
- ___ Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
- ___ Co-occurring mental illness and substance use disorders with more than six months duration at time of contact;
- ___ High risk of recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole, or probation;
- ___ Literally homeless, imminent risk of being homeless, or residing in unsafe housing (please note that ACT does not have housing);
- ___ Residing in an inpatient or supervised community residence, but assessed to be able to live in a more independent living situation if intensive services are provided; requiring a residential or institutional placement if intensive services are not available.

AND

4. ___ Difficulty effectively utilizing traditional case management or office-based outpatient services, or evidence that they require a more assertive and frequent non-office based service to meet their clinical needs.

Please note that the following are excluded if Primary Diagnoses:

1. The primary diagnosis of Axis II.
2. The primary diagnosis is Substance Abuse and/or Substance Dependence (any type) without an included co-occurring diagnosis from the above list.
3. The primary diagnosis is a Rule Out Diagnosis.
4. The primary diagnosis is secondary to a medical condition.
5. The primary diagnosis is substance induced.
6. The primary diagnosis is related to a substance intoxication or withdrawal syndrome without a co-occurring diagnosis from the above list.
7. The primary diagnosis is listed as Not Otherwise Specified.

Axis II diagnosis, Mild Mental Retardation diagnosis, and Substance Abuse or Dependence diagnoses may be present if there is also an accompanying accepted primary diagnosis (ie. schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder).

Behavioral Information:

To the best of your knowledge, does the consumer have a history of any of the following behaviors? Please check if applicable.

- | | |
|--|--|
| <input type="checkbox"/> Physical Aggressiveness | <input type="checkbox"/> Drug and/or Alcohol Involvement |
| <input type="checkbox"/> Treatment Noncompliance | <input type="checkbox"/> Self-mutilation/Self-injury |
| <input type="checkbox"/> Medication Noncompliance | <input type="checkbox"/> Suicide Attempts/Gestures/Ideation |
| <input type="checkbox"/> Arson/Fire setting | <input type="checkbox"/> Homicidal Attempts/Gestures/Ideation |
| <input type="checkbox"/> Criminal Behavior and/or | <input type="checkbox"/> Perpetrator of Physical or Sexual Abuse |
| <input type="checkbox"/> Criminal Justice Sys. Involvement | <input type="checkbox"/> Other: _____ |

For all behaviors, elaborate as to the situational nature, chronicity, severity or additional circumstances related to the behaviors noted:

Psychosocial Information:

Assess to the extent to which the person being referred requires assistance, training or support in the following psychosocial areas using the following indicators: (1) Totally self sufficient (2) Needs verbal advice or guidance (3) needs some training or supervision (4) Needs substantial help (5) Totally dependent.

- | | |
|--|---|
| <input type="checkbox"/> Self-care Skills | <input type="checkbox"/> Money Management |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Cooking Skills | <input type="checkbox"/> Apartment/Residential Management |
| <input type="checkbox"/> Health Care Skills | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Community Awareness | <input type="checkbox"/> Other: _____ |

Medical Information:

Does the person being referred have a history of any of the following medical issues?

- | | |
|--|---|
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Dietary Restrictions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infectious/Communicable Diseases |
| <input type="checkbox"/> Allergic Reactions | <input type="checkbox"/> Immunodeficient Diseases |
| <input type="checkbox"/> Physical Disabilities/Prosthetics | <input type="checkbox"/> Other: _____ |

Please specify:

Current and Past Treatment History:

Current Hospitalization:

Hospital: _____ Contact: _____
Date of Admission: _____ Phone #: _____
Reason for Admission: _____

Current Outpatient/Psychiatric Treatment/Community Supports:

Agency: _____
Type of Program: _____
Primary Therapist Name/Contact Person: _____
Address: _____ Phone: _____

Current Primary Care Physician:

Name or Practice: _____
Address: _____ Phone: _____

Previous Hospitalizations:

Admission date to discharge date	Hospital	Length of Stay	Copy of record attached
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous mental health providers:

<u>Dates of service</u>	<u>Provider Name</u>	<u>Address</u>	<u>Phone</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications:

Please list all current medications (both psychotropic and medical)

Medication	Dosage	Frequency	Prescribing Physician

Allergies: _____

Is the individual being referred compliant with his or her medication? _____ Explain: _____

This referral from is intended to obtain information necessary to determine the eligibility of the referred person for ACT services. No referral should be made to the ACT program without the knowledge and consent of the referred person. Please send the following documentation along with this referral:

1. Copies of records from recent hospitalizations and mental health treatment (within past year), and please document knowledge of any known mental health treatment for the past 7 years if available. (e.g. inpatient hospitalizations, outpatient, other ACT/CTT services, case management, day treatment, residential, dual diagnosis, etc)
2. A copy of all insurance cards.

ACT will contact the person making the referral and the referred individual once the referral is received. An initial screening interview or interviews will be scheduled with the referred individual at which point ACT will attempt to obtain releases of information for any treatment providers or other resources to assist in making a determination. Final determination of appropriateness for ACT services will be made following the screening process. Upon determination of appropriateness for ACT, and agreement on the treatment plan, the referred individual will be assigned an admission date. Any interested family, friends, or other supports are welcome and encouraged to attend the screening interviews.

Name of Person Completing Form

Signature of Person Completing Form

Date

Signature of Person Being Referred

Date

This is the **Assertive Community Treatment Transition Readiness Scale® (ATR®)**. Each item is scored on a four-point scale: strongly disagree (1), disagree (2), agree (3), strongly agree (4). For example, Item 1 reads, "He/she no longer needs intensive services." If you strongly agree with this statement, a consumer would receive a score of 4 for this item. Before computing Total or Mean scores, the responses to Items 5, 7, 12, and 17 must be reverse-scored. So, if you respond strongly disagree (1) to Item 5, this response should be reverse-scored to 4 before computing Total or Mean scores. At least 14 of the 18 items must be completed before scoring the ATR®. A Total score can be computed by adding up all item responses. Total scores range from 18 to 72. Mean scores can be computed by adding up all item responses and dividing by the number of completed items. Mean scores range from 1.0 to 4.0. Higher Total and Mean scores indicate greater potential to transition from ACT to less intensive services.

Questions about the ATR® should be addressed to Gary S. Cuddeback, Ph.D., University of North Carolina at Chapel Hill, 325 Pittsboro Street, CB#3550, Chapel Hill, NC, 27599, 919.962.4363, cuddeback@mail.schsr.unc.edu.

NAME _____ DATE _____ TOTAL or MEAN SCORE _____

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. He/she no longer needs intensive services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. He/she has structure in his/her daily life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. His/her symptoms have been stable over the last six months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. He/she has had stable housing over the last several months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. He/she has been in the psychiatric hospital within the last six months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. He/she has insight into his/her mental illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. He/she has been incarcerated within the last six months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. He/she has benefits in place.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. He/she is engaged in treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. He/she is independent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. He/she is compliant with his/her medication.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. He/she has complex needs (i.e., personality disorders, health problems, substance use).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. He/she has adequate resources.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. He/she has social support.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. He/she is gainfully employed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. He/she keeps appointments without help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. His/her behaviors have not been stable over the last six months.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. He/she has met his/her treatment goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>